Cancer de Mama

Application for Assistance

Date of Application: _______/________/________ (Year/Month/Day)

CONTACT INFORMATION:

Name: ____ Phone:__________________

Address: ____

City: ____________________________________ State: ________________________

Email: ____ Age: _____________

TREATMENT INFORMATION:

Date you found out about your medical condition/diagnosis: _______________________

Diagnosis: ____

____

____

What kind of medical treatment do you need? ___________________________________

____

____

Date treatments will start (Y/M/D): ___/___/___ Date treatments will end: ___/___/___

Where will you receive your treatments? _______________________________________

____

FINANCIAL ASSISTANCE INFORMATION:

Amount requested from Cancer de Mama: $ ________________________________

Time period this assistance will cover: _________________ to _________________

Have you applied elsewhere for funding? (circle one) YES NO

Reason for assistance: ____

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____

Please describe how you will use this assistance money if it is granted:

____

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____

*You must attach a medical report from your doctor confirming your diagnosis and treatment plan.

*You will be required to submit a quarterly report of your treatment progress and costs so correct financial support can be provided.

WHAT NOW?

Bring your completed forms (and doctors' reports) to one of the following locations.

- La Penita RV Park Office (during Nov-April) OR
- Tere Maldonado at Ferreteria Pina in La Penita, Nayarit